

STATE OF CONNECTICUT  
BOARD OF EXAMINERS FOR NURSING

1983 0527 011 013

IN RE:

Olga Sharkey, L.P.N.  
261 Lakeside Boulevard East  
Waterbury, CT 06708

LIC # 004050

MEMORANDUM OF DECISION

The Board of Examiners for Nursing was presented by the Department of Health Services with a Notice of Hearing and Statement of Charges dated December 6, 1983 and December 7, 1983, respectively.

The Statement of Charges alleged violations of certain provisions of Chapter 378, Connecticut General Statutes. The Notice of Hearing provided that the hearing would take place on January 5, 1984 and the subsequent notification on February 7, 1984 provided that the hearing was re-scheduled to February 23, 1984 in the State Armory at 360 Broad Street, Hartford, Connecticut.

Each member of the Board of Examiners for Nursing involved in this decision attests that he/she has reviewed the record, and that this decision is based entirely on the record.

FACT

1. Olga Sharkey, respondent, was at all pertinent times licensed to practice nursing as a practical nurse in Connecticut, with registration number 4050.



STATE OF CONNECTICUT  
DEPARTMENT OF HEALTH SERVICES  
DIVISION OF MEDICAL QUALITY ASSURANCE

Olga Sharkey, L.P.N.  
261 Lakeside Boulevard East  
Waterbury, CT 06708

Ms. Sharkey, License Number 4050

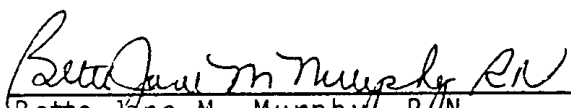
This letter is to notify you of the action of the Board of Examiners for Nursing as the result of your hearing conducted on February 23, 1984.

After two reviews of the evidence, testimony and late exhibits presented by you and your attorney relative to charges brought against you at the February, 1984 hearing, the following action was taken by the Board: You are hereby reprimanded for:

1. inaccurate documentation on health agency records which reflect medications administered and
2. poor medication administration techniques as evidenced by the undetected medication error.

Please be advised that a copy of this letter will be retained in your file and will be available for the Board of Examiners for Nursing consideration if there are any subsequent charges brought against you.

BOARD OF EXAMINERS FOR NURSING

  
Bette Jane M. Murphy, R.N.  
Chairman

DATE 1/15/84

Phone:

150 Washington Street — Hartford, Connecticut 06106  
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2. Pursuant to Connecticut General Statutes, Section 4-182(c), the respondent was provided a full opportunity prior to the institution of agency action to show compliance with all the terms for the retention of her license.

3. The respondent, a) on or about March 14, 1984, administered the controlled substance Darvocet N to a patient who did not have a physician's order for this medication; b) on or about March 23, 1983, recorded a dose of Darvocet on the controlled substance proof of use sheet but failed to record this dose on the medication administration record.

4. The activities referenced in paragraph three (3) were uncovered by Drug Control Agents William P. Cadwell and Henry Karanian, Department of Consumer Protection during an investigation conducted during March and April, 1983.

#### DISCUSSION

5. The First Count alleges that the respondent violated provisions of Section 20-99(b) in that, on or about March 9, 1983 she recorded a dose of Darvocet on the controlled substance proof of use sheet but failed to record this dose on the medication administration record for the patient in question. The evidence received by the Board does not establish a violation of Section 20-99(b) and, accordingly, this count is dismissed.

6. The Second Count alleges that the respondent violated provisions of Section 20-99(b) by administering the controlled substance Darvocet N to a patient who did not have a physician's order for this medication.

In pertinent part, Section 20-99(b) forbids (2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The Board determined on or about March 14, the respondent administered the controlled substance Darvocet-N to a patient, R. Laire, who did

not have a physician's order for this medication. The respondent stated she administered an Imodium to R. Laire which she borrowed from A. Blansfield. A. Blansfield also had a supply of Darvocet-N. A. Blansfield's controlled drug record shows an entry on March 14, 1983 for one (1) Darvocet-N borrowed for R. Laire by the respondent. Further analysis of the records of the two patients and the fact the count was correct at 3 p.m. on March 14, 1983 demonstrates that, in all probability, a medication error was made by the respondent.

Standards of medication administration include administering the right drug to the right patient.

Based on the foregoing, the Board concludes that the respondent has violated Section 20-99(b) as specified in the Second Count.

7. The Third Count alleges that the respondent violated provisions of Section 20-99(b) by recording a dose of Darvocet on the controlled substance proof of use sheet but failing to record this dose on the medication administration record for the patient.

In pertinent part, Section 20-99(b) forbids: ...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions.

The Board determined that the respondent did document a dose of Darvocet on the controlled substance sheet for March 23, 1983 which was not recorded on the patient's medication administration record and nurse's notes on March 23, 1983. Review of other entries on all three documents demonstrated the dose of Darvocet was in all probability administered on March 22, 1983, documented as March 23, 1983 on the controlled substance sheet, and documented as March 22, 1983 on the patient's medication administration record and nurse's note.

Standards of nursing practice dictate correct documentation of controlled substances on all health agency records.

Based on the foregoing, the Board concludes that the respondent has violated Section 20-99(b) as specified in the Third Count.

ORDER

8. It is the unanimous decision of the Board of Examiners for Nursing that:

The respondent be reprimanded for poor record keeping and a probable medication error. Standards of nursing dictate careful medication administration techniques and documentation. The records submitted demonstrated inaccurate documentation and poor medication administration technique.

Dated at Hartford, Connecticut, this 15<sup>th</sup> day of November, 1984

BOARD OF EXAMINERS FOR NURSING

BY: Bette Jane M. Murphy, R.N.  
Bette Jane M. Murphy, R.N., Chairman